

HEALTH HISTORY

TO OUR PATIENTS:

Although oral and maxillofacial surgeons treat the area in and around your mouth, your mouth is part of your entire body. Any health problems you have or medications you take could affect the care you are receiving. Thank you for answering the following questions. Your answers are confidential and are for our records only.

YES NO
 Are you in good health?
 Have there been any changes in your general health in the past year?
 Are you under the care of a physician?
 Date of last visit: _____
 If so, for what are you being treated?

When did you last have anything to eat or drink?

YES NO
 Have you been hospitalized or had any operations in the past five years? If "yes", please state what was done: _____

 Are you taking any drugs or medications? *Please list them:* _____

Have you ever taken part in a weight loss program where drugs were prescribed?

HAVE YOU HAD OR DO YOU CURRENTLY HAVE . . .		Yes	No	NOTES	HAVE YOU HAD OR DO YOU CURRENTLY HAVE . . .		Yes	No	NOTES
1	Rheumatic fever?				26	Infectious mononucleosis?			
2	Damaged heart valves/mitral valve prolapse?				27	Fainting spells?			
3	Any pre-medication before dental care?				28	Convulsions, epilepsy?			
4	Heart murmur?				29	Stroke?			
5	High blood pressure?				30	Thyroid problem?			
6	Low blood pressure?				31	Diabetes?			
7	Chest, pain, angina?				32	Low blood sugar?			
8	Heart attack(s)?				33	Kidney trouble?			
9	Irregular heart beat?				34	Are you on dialysis?			
10	Cardiac pacemaker?				35	Swollen ankles, arthritis or joint disease?			
11	Heart surgery?				36	Any artificial joints?			
12	Artificial heart valves or artery grafts?				37	Stomach ulcers?			
13	Bronchitis, chronic cough?				38	A tumor, growth or cancer?			
14	Asthma?				39	Mental health problems?			
15	Hayfever/sinus problems?				40	Removable dentures or retainers?			
16	Tuberculosis?				41	Have you taken diet pills including fenfluramine?			
17	Emphysema?				42	Eye disease/glaucoma?			
18	Difficulty breathing?				43	Radiation treatment/chemotherapy?			
19	Any other lung trouble?				44	Blood transfusion?			
20	Do you smoke? How many a day?				45	Jaw joint or TMJ pain, clicking, or trouble opening your mouth?			
21	Blood disorder such as anemia?				46	Sexually transmitted diseases?			
22	Bruise easily?				47	Any disease, use any drugs, or had a transfusion, transplant, or other operation which depressed your immune system?			
23	Bleeding tendency (abnormal bleeding)?								
24	Jaundice, hepatitis, or liver disease?								
25	Are you taking any natural products? Herbal supplements, tea or other natural remedies.								

ALLERGIES	YES	NO
ARE YOU ALLERGIC OR HAD A REACTION TO:		
Local anesthetics (novocaine)?	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin?	<input type="checkbox"/>	<input type="checkbox"/>
Other Antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills?	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin?	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics?	<input type="checkbox"/>	<input type="checkbox"/>
Other medications?	<input type="checkbox"/>	<input type="checkbox"/>
Latex products or rubber gloves?	<input type="checkbox"/>	<input type="checkbox"/>
Allergies other than drug allergies? (<i>Please list</i>)	<input type="checkbox"/>	<input type="checkbox"/>

YES NO

IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?
Please indicate: _____

FOR WOMEN ONLY:
 Are you using birth control pills?
 Are you nursing?
 Are you pregnant?
 Estimated date baby is due?
 Might you be or are you trying to become pregnant?
 Do you wish to consult with your physician to rule out pregnancy before oral surgery?
 Is there anything you wish to discuss in private with your oral surgeon?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient, Parent, Guardian: _____